

Seclusion and Restraint Reduction Intervention Advisory Council Meeting Minutes

May 21st, 2009 at 1:30 pm

Location: VSH Library

Type of meeting: Advisory

Facilitator: Ed Riddell, Alternatives to Seclusion and Restraint Coordinator at VSH

Note taker: Ed Riddell

Advisory Council Members: Cathy Rickerby, NAMI Vermont; Sherry Silva, VP&A; Jane Winterling, VPS; Bill McMains, DMH; David Mitchell, VSH; Terry Rowe, VSH; Janet Isham, VSH; Patrick Kinner, VSH; Tommie Murray, VSH; and Scott Perry, VSH.

Absent: Anne Jerman, VSH; John O'Brien, VSH; and Jay Batra, VSH.

Guests: Michael Sabourin and Norma Wasco.

Discussion: Opening

Ed Riddell opened the meeting and welcomed all members and attendees. Sherry Silva from VP&A will be representing for Ed Paquin over the next two months, so introductions were done.

Discussion: Approval of April Minutes

ER introduced the April minutes for approval. After a brief review by members, David Mitchell moved to accept the minutes as previously amended. Bill McMains provided the second and the motion carried unanimously.

Discussion: Advice provided on Interim Emergency Involuntary Procedure Policy

ER opened the discussion by explaining that several modifications and language changes had occurred to the policy which reflected real interventions suggested by the SAMHSA 6 Core Strategies Leadership goal. The additions reflected; the identification of S/R reduction as a goal, the support of the adoption of recovery principles, the support of a trauma-informed system, the creation of violence- and coercion-free environments, the provision of a safe environment for consumers and staff through a violence prevention approach. Jane Winterling passionately asked to provide her input as she had done much work in preparation for this discussion. JW explained that the policy needs to connect to the treatment, crisis, behavioral, etc. plans that are created for the people served at VSH. She believes that policy must create expectations that direct care givers will use those plans prior to the use of an EIP. Michael Sabourin added that crisis plans could be useful, debriefing language needs to be added and notifications to family members upon the use of an EIP procedure be emphasized to patients coming into the hospital. JW continued to outline changes she would like reflected into the policy and emphasized that crisis plans be implemented. Cathy Rickerby asked how direct care staff members respond now when there are no crisis plans in use. Terry Rowe explained that currently crisis response planning is included in the treatment plan and treatment plans are available for use to help a person in crisis. JW explained that many persons served are not aware that crisis

plans are something that they might need and crisis plans should be included in the policy. TR provided insight that Psychiatry and Psychiatric care is a relatively young science and there is much to be learned and studied. She added that due to this situation, these emergency procedures (S/R/EIM) are still part of the capacity. MS added that he was aware that procedures are used for different reasons as well. MS explained that some persons served request restraint and seclusion for their own use. A general discussion about current language used in the policy and how it did not necessarily reflect best practice was had among several attendees and was specifically directed at several lines in the policy. BM suggested that much of that language is older in nature. Scott Perry, who is part of the VSH Policy Committee, said that the committee will consider all policy modifications and concurred that some of the language exists from older versions of the policy and from language that was specifically required by the Doe v. Miller settlement. JW suggested that some middle ground around language must exist, but she did not know what it was at this time. CR asked if there were generally accepted professional standards in reference to one of the lines written in the policy. BM explained that the referenced line was older language and that as a profession Psychiatry was beyond those vaguely written terms and uses much clearer language to describe standards at this time. DM added that the reference to “generally accepted” had to exist, since it encompassed small and large hospitals alike. DM explained that care levels are different depending on the facilities capacity. SS asked if there are really two different levels of care. DM provided the example that at Fletcher Allen Hospital they use a certain care regime/schedule to provide attending psychiatrists, while at VSH it is different due to the level of care required. Tommie Murray provided the insight that the referenced sentence did not appear to have any value in the document at all. BM and others agreed. TM suggested that there are likely other lines that could just be removed. CR and others suggested adding language that established the requirement to always use the person’s existing plan before any EIP could be used. TR cautioned that in the case of an immediately dangerous behavior there may not be time to utilize the plan in all situations. CR explained that the language should then reflect that in those immediate situations the behavior was so dangerous that the response made sense. Attendees moved the discussion to the need for crisis plans. TM added that currently behavioral plans act as crisis plans, along with treatment plans, but that VSH needs to do more to develop more efficient plans. BM taught that crisis plans are used in anticipation of a crisis and behavior plans is developed in response to an occurred crisis, so that future crisis can be better managed or responded too. TM reflected that the policy modifications needed to create language that was currently operational and provide reference to future add-ons, like the separate crisis plans. JW suggested that a reference to a general “behavioral” plan might suffice and then educating persons served and staff that a specific plan, like the crisis plan, would fall under that general plan description in policy. SS asked why it might take a long time to create crisis plans for use at VSH. TM explained that crisis plans would need to directly connect to the treatment plan of care for the person served. TM shared that the treatment planning process is going through a major improvement process, which is resource intensive and complex. The process changes is still occurring and as most process changes occur at a fairly modest rate, this change is no different and will take more time to complete. SP reminded attendees that anyone can provide information to be used in policy by providing input directly to the VSH Policy Committee or via the DMH website. JW asked to address a few more items of concern in the policy. She expressed concern that the time allowed for a physician to write an order for a procedure (4 hours) is too long and more resources need to be provided by DMH to help address issues that impact on the use of S/R, like improving the facility’s environment for the persons served and getting the New Directions Pavilion reopened. CR questioned why it is taking so long to box up the overhead pipes in the new treatment and recovery area so it can be used again. Several attendees commented about their support for reopening the new treatment activities area as well as it would largely benefit the crowded environment on the units. A question was raised about the purpose of policy and

procedure. TR responded that policy is a document that is created to help staff stay with in the many legal and regulatory guidelines of all the rules, laws, and agreements that have been made which impact the hospital and the care it provides. Upon any changes in these rules, laws or agreements the policy is modified. BM suggested that JW's input about the need for DMH to provide more resources to VSH when needed, should go directly to DMH. JW encouraged that in times of need for VSH, there should be a collaborative push forward from all supporters. TR said that she and VSH would be open to all support. MS added that he thought that patients would benefit from training and the provision of policy and procedure. MS explained how he was aware that some patients were critical of staff when fellow patients act violently, but then seemingly have no consequence to their behavior. The critical people might benefit by knowing the guidance from policy. Several attendees began a discussion on crowding in the hospital and how support can be developed. JW suggested that if the VSH Administration asks for outside support then the AC members need to move up to help as they can. The discussion then moved to how best to support the VSH at this time. TR asked that AC members reserve their marshaled support for now and reminded members that this is a public body who can advocate. TR suggested that the question to be answered is how can you advocate for the patients currently being served at VSH. SS asked if there are service user meetings that occur in Vermont. Several attendees responded in the affirmative. CR suggested that the Seclusion and Restraint Reduction Interventions (SRRI) Advisory Council meeting minutes be used. CR claims that the minutes are clear and that she can forward them on to concerned others as a support building/information providing tool. CR opined again that it is too bad that regulators closed down the new treatment activities mall. TR explained further that it was only CMS who denied use of the area and that the Department of Justice, Joint Hospital Accreditation, and SAMHSA grant consultants (who are MA-DMH Licensing regulators) all agreed that the area was safe to use. TR also suggested that in these current times when the hospital census is running high at 52 patients and staff members have recently been injured, having the extra treatment space would be very beneficial. SP opined that we are all spokespersons for the patients at VSH and we should be advocating on their behalf at every opportunity. Several attendees voiced agreement. In closing of this discussion, BM asked that the AC receive information in the future about how JW, and others, suggestions for changing the Interim Emergency Involuntary Procedures Policy were included or used to modify the policy.

Discussion: Advising for the Comfort Room Intervention

ER opened the discussion by explaining that we have now begun the comfort room intervention by opening this discussion and he emphasized that this is a project that the AC is involved with from the start. ER highlighted that JW and Ed Paquin will be touring VSH with Anne Jerman on June 3rd to explore the possibilities for comfort room creation in the hospital. ER will work with CR, who may be joined by BM, for a tour with AJ after June 17th. CR immediately asked what the budget for the project is. TR explained that there are funds in the VSH budget for use on comfort room development, but no amount is defined at this time. JW shared that from her experience, furniture is expensive and that it will be crucial to involve patients and staff members in the creation of the comfort rooms. JW encouraged that focus groups be conducted with patients and staff members to receive their input and bring such input back to the AC. CR asked if there was consensus on which space(s) would be used. TR responded that it would need to be determined as this intervention project develops. TM explained that there is a room on the new treatment mall that was designated as a comfort room, but it is off unit, and cannot currently be accessed by patients. TR further explained the current limitations to implementing this intervention is that patient rooms or other like spaces would likely need to be used on the units. BM and CR unanimously responded

that the goal is to have one comfort room on each unit. TM asked JW what kind of focus groups she has found worked well during her recent experience in conducting such groups at the Brattleboro Retreat. JW explained that in many facilities it is the Consumer staff or Patient Representative that manages the comfort room. Rooms are locked until a person requests the use of the room, so that other problems can be avoided. Staff involvement and patient input are crucial or the rooms run the risk of not being used. In the process, a focus group's input would be brought to the advisory council and then forwarded on to hospital leadership. Comfort rooms and sensory modulation practices are seen as separate interventions, but sensory modulation tools can be brought into the comfort room for use. JW emphasized that the project must start with focus groups. JW then discussed that stick up murals are better than painting. JW interjected that in developing the comfort rooms, an effort must be made to see where people want to expand energy and then allow a process to develop that includes their momentum going forward. CR asked if the comfort rooms are designed to allow for the release of energy. CR believed that the comfort rooms are designed for quiet and she suggested the use of a WII to release energy. JW suggested that a comfort room could allow for both. MS suggested that a place be designed where people can destroy things. JW and others shared that facilities have found that punching bags, foam bats, etc. have not been helpful in reducing anxiety and have not led to diminished violence by providing destructive opportunities. JW suggested that free form dancing might be allowed. TR suggested that the space(s) need to be assessed with an eye on keeping them safe. Janet Isham reminded members of the difficulty staff have in keeping things safe to a level that the CMS require and providing opportunities for persons served to use many of the suggested calming strategies and items. JI said that a comfort room would be great, but that space would be tough to find unless a patient room was converted and then the census on the unit would have to be adjusted down by one. TM suggested that during this earliest part of the intervention, that we consider all the things that might be possible and holds off on the addressing of limitations until we actually start to plan implementation of the comfort rooms. All members seemed to be in agreement and the next step will be the AC member tours of the units with AJ.

Discussion: Data Presentation

ER opened this discussion by presenting a portion of the “Results from the First Round of Alternatives to Restraint & Seclusion (ARS) State Infrastructure Grant (SIG) Program” presentation made by Steve Leff of Human Services Research Institute (HSRI) on April 28th, 2009 at the SAMHSA sponsored annual grant meeting in Bethesda, MD. ER explained that Mr. Leff had found four different models of how different facilities had implemented the grant suggested interventions during the prior grant cohort from 2004 to 2007. It was determined that the most successful implementation was a model that progressed over the three year period from baseline to increasing intervention implementation to a plateau of implemented interventions that were stabilized and continued until the end of the grant period. Success was observed as the largest reduction in the use of restraint and seclusion. SP then provided the S/R use graphs for the past 6 months as requested by the AC. BM responded that he would be more interested in reviewing S/R use data once VSH has gotten into the stabilization phase of intervention implementation and that he did not expect data to change very much until that time period. BM would also like to see interventions added to the time line going forward so that changes can be compared to the implementation of different interventions. CR asked to have “near miss” data collection developed and said that she believed that it is being done in another facility that she recently learned about. (ER will need to follow up on that information.) JI asked how “near miss” events could be determined. SP suggested that this would make a great direct care staff developed intervention

and that there is the ability for events to be entered into the current risk management software if a definition of near miss and a process for entering could be developed.

Public Input:

MS interjected that he hoped that in the development of the interventions that punching things could be used.

Adjournment:

Next Meeting:

Thursday, June 11th, 2009 at 1:00 pm in the VSH Library

Respectfully submitted,

Ed Riddell

Notetaker